Omnibus Codes

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➲ Instructions for Use

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Coverage Rationale

This UnitedHealthcare Medicare Advantage Medical Policy is intended to be used when there are no Medicare coverage criteria or other UnitedHealthcare Medicare Advantage Medical Policies that include omnibus codes.

For coverage guidelines for items and services **not** listed in this policy, first search the Medicare Coverage Database to confirm no applicable Medicare coverage guidelines exist. After searching the Medicare Coverage Database, if no National Coverage Determination (NCD)/Local Coverage Determination (LCD)/Local Coverage Article (LCA) is found, then search for a UnitedHealthcare Medicare Advantage Medical Policy that specifically addresses the service/code. If none is found, refer to the table below.

Note: Bracketed language following the unlisted code descriptions was added by UnitedHealthcare to indicate the intended use of the code within this policy.

Code	Description	CMS NCD Coverage Criteria	CMS LCD/LCA Coverage Criteria	Conclusion
0061U	Transcutaneous measurement of five biomarkers (tissue oxygenation [StO2], oxyhemoglobin [ctHbO2], deoxyhemoglobin [ctHbR], papillary and reticular dermal hemoglobin concentrations [ctHb1 and ctHb2]), using spatial frequency domain imaging (SFDI) and multi-spectral analysis	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0075T	Transcatheter placement of extracranial vertebral artery stent(s), including radiologic supervision and interpretation, open or percutaneous; initial vessel	No	**WPS*** L35490	**For coverage guidelines for states/territories with no LCDs/LCAs**, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

Code	Description	CMS NCD Coverage Criteria	CMS LCD/LCA Coverage Criteria	Conclusion
0076T	Transcatheter placement of extracranial vertebral artery stent(s), including radiologic supervision and interpretation, open or percutaneous; each additional vessel (List separately in addition to code for primary procedure)	No	**WPS*** L35490	**For coverage guidelines for states/territories with no LCDs/LCAs**, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0100T	Placement of a subconjunctival retinal prosthesis receiver and pulse generator, and implantation of intra-ocular retinal electrode array, with vitrectomy	No	**CGS** (A54327)	**For coverage guidelines for states/territories with no LCDs/LCAs**, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0163U	Oncology (colorectal) screening, biochemical enzyme-linked immunosorbent assay (ELISA) of 3 plasma or serum proteins (teratocarcinoma derived growth factor-1 [TDGF-1, Cripto-1], carcinoembryonic antigen [CEA], extracellular matrix protein [ECM]), with demographic data (age, gender, CRC-screening compliance) using a proprietary algorithm and reported as likelihood of CRC or advanced adenomas	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0174T	Computer-aided detection (CAD) (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation and report, with or without digitization of film radiographic images, chest radiograph(s), performed concurrent with primary interpretation (List separately in addition to code for primary procedure)	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0175T	Computer-aided detection (CAD) (computer algorithm analysis of digital image data for lesion detection) with further physician review for interpretation and report, with or without digitization of film radiographic images, chest radiograph(s), performed remote from primary interpretation	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0207T	Evacuation of meibomian glands, automated, using heat and intermittent pressure, unilateral	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0208T	Pure tone audiometry (threshold), automated; air only	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

Code	Description	CMS NCD Coverage Criteria	CMS LCD/LCA Coverage Criteria	Conclusion
0209T	Pure tone audiometry (threshold), automated; air and bone	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0210T	Speech audiometry threshold, automated	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0211T	Speech audiometry threshold, automated; with speech recognition	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0212T	Comprehensive audiometry threshold evaluation and speech recognition (0209T, 0211T combined), automated	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0234T	Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation; renal artery	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0235T	Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation; visceral artery (except renal), each vessel	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0236T	Transluminal peripheral atherectomy, open or percutaneous, including radiological supervision and interpretation; abdominal aorta	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0247U	Obstetrics (preterm birth), insulin-like growth factor-binding protein 4 (IBP4), sex hormone-binding globulin (SHBG), quantitative measurement by LC-MS/MS, utilizing maternal serum, combined with clinical data, reported as predictive-risk stratification for spontaneous preterm birth	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

Code	Description	CMS NCD Coverage Criteria	CMS LCD/LCA Coverage Criteria	Conclusion
0266T	Implantation or replacement of carotid sinus baroreflex activation device; total system (includes generator placement, unilateral or bilateral lead placement, intra-operative interrogation, programming, and repositioning, when performed) (Deleted 12/31/2025 – See 64654, 64655, 64656)	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0267T	Implantation or replacement of carotid sinus baroreflex activation device; lead only, unilateral (includes intra-operative interrogation, programming, and repositioning, when performed) (Deleted 12/31/2025 – See 64655)	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0268T	Implantation or replacement of carotid sinus baroreflex activation device; pulse generator only (includes intra-operative interrogation, programming, and repositioning, when performed) (Deleted 12/31/2025 – See 64656,)	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0269T	Revision or removal of carotid sinus baroreflex activation device; total system (includes generator placement, unilateral or bilateral lead placement, intra-operative interrogation, programming, and repositioning, when performed) (Deleted 12/31/2025 – See 64655, 64656, 64657)	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0270T	Revision or removal of carotid sinus baroreflex activation device; lead only, unilateral (includes intra-operative interrogation, programming, and repositioning, when performed) (Deleted 12/31/2025 – See 64655, 64658)	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0271T	Revision or removal of carotid sinus baroreflex activation device; pulse generator only (includes intra-operative interrogation, programming, and repositioning, when performed) (Deleted 12/31/2025 – See 64656, 64659)	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0272T	Interrogation device evaluation (in person), carotid sinus baroreflex activation system, including telemetric iterative communication with the implantable device to monitor device diagnostics and programmed therapy values, with interpretation and report (e.g., battery status, lead impedance, pulse amplitude, pulse width, therapy frequency, pathway mode, burst mode, therapy start/stop times each day) (Deleted 12/31/2025 – See 93145 and 93146)	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

Code	Description	CMS NCD Coverage Criteria	CMS LCD/LCA Coverage Criteria	Conclusion
0273T	Interrogation device evaluation (in person), carotid sinus baroreflex activation system, including telemetric iterative communication with the implantable device to monitor device diagnostics and programmed therapy values, with interpretation and report (e.g., battery status, lead impedance, pulse amplitude, pulse width, therapy frequency, pathway mode, burst mode, therapy start/stop times each day); with programming (Deleted 12/31/2025 – See 93145 and 93146)	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0330T	Tear film imaging, unilateral or bilateral, with interpretation and report	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0331T	Myocardial sympathetic innervation imaging, planar qualitative and quantitative assessment	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0332T	Myocardial sympathetic innervation imaging, planar qualitative and quantitative assessment; with tomographic SPECT	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0333T	Visual evoked potential, screening of visual acuity, automated, with report	No	**NGS** L36831 (A57060)	**For coverage guidelines for states/territories with no LCDs/LCAs**, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0335T	Insertion of sinus tarsi implant	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0338T	Transcatheter renal sympathetic denervation, percutaneous approach including arterial puncture, selective catheter placement(s) renal artery(ies), fluoroscopy, contrast injection(s), intraprocedural roadmapping and radiological supervision and interpretation, including pressure gradient measurements, flush aortogram and diagnostic renal angiography when performed; unilateral	Yes	No	Refer to the NCD for Renal Denervation (RDN) for Uncontrolled Hypertension (20.40)

Code	Description	CMS NCD Coverage Criteria	CMS LCD/LCA Coverage Criteria	Conclusion
0339T	Transcatheter renal sympathetic denervation, percutaneous approach including arterial puncture, selective catheter placement(s) renal artery (ies), fluoroscopy, contrast injection(s), intraprocedural roadmapping and radiological supervision and interpretation, including pressure gradient measurements, flush aortogram and diagnostic renal angiography when performed; bilateral	Yes	No	Refer to the NCD for Renal Denervation (RDN) for Uncontrolled Hypertension (20.40)
0347T	Placement of interstitial device(s) in bone for radiostereometric analysis (RSA)	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0348T	Radiologic examination, radiostereometric analysis (RSA); spine, (includes cervical, thoracic, and lumbosacral, when performed)	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0349T	Radiologic examination, radiostereometric analysis (RSA); upper extremity(ies), (includes shoulder, elbow, and wrist, when performed)	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0350T	Radiologic examination, radiostereometric analysis (RSA); lower extremity(ies), (includes hip, proximal femur, knee, and ankle, when performed)	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0358T	Bioelectrical impedance analysis whole body composition assessment, with interpretation and report	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0397T	Endoscopic retrograde cholangiopancreatography (ERCP), with optical endomicroscopy (List separately in addition to code for primary procedure)	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0408T	Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; pulse generator with transvenous electrodes	Yes	No	Refer to the NCD for Cardiac Contractility Modulation (CCM) for Heart Failure (HF) (20.39)

Code	Description	CMS NCD Coverage Criteria	CMS LCD/LCA Coverage Criteria	Conclusion
0409T	Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; pulse generator only	Yes	No	Refer to the NCD for Cardiac Contractility Modulation (CCM) for Heart Failure (HF) (20.39)
0410T	Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; atrial electrode only	Yes	No	Refer to the NCD for Cardiac Contractility Modulation (CCM) for Heart Failure (HF) (20.39)
0411T	Insertion or replacement of permanent cardiac contractility modulation system, including contractility evaluation when performed, and programming of sensing and therapeutic parameters; ventricular electrode only	Yes	No	Refer to the NCD for Cardiac Contractility Modulation (CCM) for Heart Failure (HF) (20.39)
0412T	Removal of permanent cardiac contractility modulation system; pulse generator only	Yes	No	Refer to the NCD for Cardiac Contractility Modulation (CCM) for Heart Failure (HF) (20.39)
0413T	Removal of permanent cardiac contractility modulation system; transvenous electrode (atrial or ventricular)	Yes	No	Refer to the NCD for Cardiac Contractility Modulation (CCM) for Heart Failure (HF) (20.39)
0414T	Removal and replacement of permanent cardiac contractility modulation system pulse generator only	Yes	No	Refer to the NCD for Cardiac Contractility Modulation (CCM) for Heart Failure (HF) (20.39)
0415T	Repositioning of previously implanted cardiac contractility modulation transvenous electrode, (atrial or ventricular lead)	Yes	No	Refer to the NCD for Cardiac Contractility Modulation (CCM) for Heart Failure (HF) (20.39)
0416T	Relocation of skin pocket for implanted cardiac contractility modulation pulse generator	Yes	No	Refer to the NCD for Cardiac Contractility Modulation (CCM) for Heart Failure (HF) (20.39)
0417T	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, including review and report, implantable cardiac contractility modulation system	Yes	No	Refer to the NCD for Cardiac Contractility Modulation (CCM) for Heart Failure (HF) (20.39)
0418T	Interrogation device evaluation (in person) with analysis, review and report, includes connection, recording and disconnection per patient encounter, implantable cardiac contractility modulation system	Yes	No	Refer to the NCD for Cardiac Contractility Modulation (CCM) for Heart Failure (HF) (20.39)

Code	Description	CMS NCD Coverage Criteria	CMS LCD/LCA Coverage Criteria	Conclusion
0444T	Initial placement of a drug-eluting ocular insert under one or more eyelids, including fitting, training, and insertion, unilateral or bilateral	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0445T	Subsequent placement of a drug-eluting ocular insert under one or more eyelids, including re-training, and removal of existing insert, unilateral or bilateral	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0472T	Device evaluation, interrogation, and initial programming of intraocular retinal electrode array (e.g., retinal prosthesis), in person, with iterative adjustment of the implantable device to test functionality, select optimal permanent programmed values with analysis, including visual training, with review and report by a qualified health care professional	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0473T	Device evaluation and interrogation of intraocular retinal electrode array (e.g., retinal prosthesis), in person, including reprogramming and visual training, when performed, with review and report by a qualified health care professional	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0485T	Optical coherence tomography (OCT) of middle ear, with interpretation and report; unilateral	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0486T	Optical coherence tomography (OCT) of middle ear, with interpretation and report; bilateral	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0506T	Macular pigment optical density measurement by heterochromatic flicker photometry, unilateral or bilateral, with interpretation and report	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0507T	Near-infrared dual imaging (i.e., simultaneous reflective and trans-illuminated light) of meibomian glands, unilateral or bilateral, with interpretation and report	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

Code	Description	CMS NCD Coverage Criteria	CMS LCD/LCA Coverage Criteria	Conclusion
0510T	Removal of sinus tarsi implant	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0511T	Removal and reinsertion of sinus tarsi implant	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0515T	Insertion of wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming, and imaging supervision and interpretation, when performed; complete system (includes electrode and generator [transmitter and battery])	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0516T	Insertion of wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming, and imaging supervision and interpretation, when performed; electrode only	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0517T	Insertion of wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming, and imaging supervision and interpretation, when performed; both components of pulse generator (battery and transmitter) only	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0518T	Removal of pulse generator for wireless cardiac stimulator for left ventricular pacing; battery component only	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0519T	Removal and replacement of pulse generator for wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming; both components (battery and transmitter)	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0520T	Removal and replacement of pulse generator for wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming; battery component only	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

Code	Description	CMS NCD Coverage Criteria	CMS LCD/LCA Coverage Criteria	Conclusion
0521T	Interrogation device evaluation (in person) with analysis, review and report, includes connection, recording, and disconnection per patient encounter, wireless cardiac stimulator for left ventricular pacing	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0522T	Programming device evaluation (in person) with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, including review and report, wireless cardiac stimulator for left ventricular pacing	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0525T	Insertion or replacement of intracardiac ischemia monitoring system, including testing of the lead and monitor, initial system programming, and imaging supervision and interpretation; complete system (electrode and implantable monitor)	No	**WPS*** L35490	**For coverage guidelines for states/territories with no LCDs/LCAs**, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0526T	Insertion or replacement of intracardiac ischemia monitoring system, including testing of the lead and monitor, initial system programming, and imaging supervision and interpretation; electrode only	No	**WPS*** L35490	**For coverage guidelines for states/territories with no LCDs/LCAs**, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0527T	Insertion or replacement of intracardiac ischemia monitoring system, including testing of the lead and monitor, initial system programming, and imaging supervision and interpretation; implantable monitor only	No	**WPS*** L35490	**For coverage guidelines for states/territories with no LCDs/LCAs**, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0528T	Programming device evaluation (in person) of intracardiac ischemia monitoring system with iterative adjustment of programmed values, with analysis, review, and report	No	**WPS*** L35490	**For coverage guidelines for states/territories with no LCDs/LCAs**, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0529T	Interrogation device evaluation (in person) of intracardiac ischemia monitoring system with analysis, review, and report	No	**WPS*** L35490	**For coverage guidelines for states/territories with no LCDs/LCAs**, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

Code	Description	CMS NCD Coverage Criteria	CMS LCD/LCA Coverage Criteria	Conclusion
0530T	Removal of intracardiac ischemia monitoring system, including all imaging supervision and interpretation; complete system (electrode and implantable monitor)	No	**WPS*** L35490	**For coverage guidelines for states/territories with no LCDs/LCAs**, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0531T	Removal of intracardiac ischemia monitoring system, including all imaging supervision and interpretation; electrode only	No	**WPS*** L35490	**For coverage guidelines for states/territories with no LCDs/LCAs**, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0532T	Removal of intracardiac ischemia monitoring system, including all imaging supervision and interpretation; implantable monitor only	No	**WPS*** L35490	**For coverage guidelines for states/territories with no LCDs/LCAs**, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0559T	Anatomic model 3D-printed from image data set(s); first individually prepared and processed component of an anatomic structure	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0560T	Anatomic model 3D-printed from image data set(s); each additional individually prepared and processed component of an anatomic structure (List separately in addition to code for primary procedure)	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0561T	Anatomic guide 3D-printed and designed from image data set(s); first anatomic guide	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0562T	Anatomic guide 3D-printed and designed from image data set(s); each additional anatomic guide (List separately in addition to code for primary procedure)	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0563T	Evacuation of meibomian glands, using heat delivered through wearable, open-eye eyelid treatment devices and manual gland expression, bilateral	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

Code	Description	CMS NCD Coverage Criteria	CMS LCD/LCA Coverage Criteria	Conclusion
0567T	Permanent fallopian tube occlusion with degradable biopolymer implant, transcervical approach, including transvaginal ultrasound (Deleted 01/01/2025)	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0568T	Introduction of mixture of saline and air for sonosalpingography to confirm occlusion of fallopian tubes, transcervical approach, including transvaginal ultrasound and pelvic ultrasound (Deleted 01/01/2025)	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0571T	Insertion or replacement of implantable cardioverter-defibrillator system with substernal electrode(s), including all imaging guidance and electrophysiological evaluation (includes defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters), when performed	Yes	No	Refer to the NCD for Implantable Cardioverter Defibrillators (ICDs) (20.4)
0572T	Insertion of substernal implantable defibrillator electrode	Yes	No	Refer to the NCD for Implantable Cardioverter Defibrillators (ICDs) (20.4)
0573T	Removal of substernal implantable defibrillator electrode	Yes	No	Refer to the NCD for Implantable Cardioverter Defibrillators (ICDs) (20.4)
0574T	Repositioning of previously implanted substernal implantable defibrillator-pacing electrode	Yes	No	Refer to the NCD for Implantable Cardioverter Defibrillators (ICDs) (20.4)
0575T	Programming device evaluation (in person) of implantable cardioverter-defibrillator system with substernal electrode, with iterative adjustment of the implantable device to test the function of the device and select optimal permanent programmed values with analysis, review and report by a physician or other qualified health care professional	Yes	No	Refer to the NCD for Implantable Cardioverter Defibrillators (ICDs) (20.4)
0576T	Interrogation device evaluation (in person) of implantable cardioverter-defibrillator system with substernal electrode, with analysis, review and report by a physician or other qualified health care professional, includes connection, recording and disconnection per patient encounter	Yes	No	Refer to the NCD for Implantable Cardioverter Defibrillators (ICDs) (20.4)

Code	Description	CMS NCD Coverage Criteria	CMS LCD/LCA Coverage Criteria	Conclusion
0577T	Electrophysiologic evaluation of implantable cardioverter-defibrillator system with substernal electrode (includes defibrillation threshold evaluation, induction of arrhythmia, evaluation of sensing for arrhythmia termination, and programming or reprogramming of sensing or therapeutic parameters)	Yes	No	Refer to the NCD for Implantable Cardioverter Defibrillators (ICDs) (20.4)
0578T	Interrogation device evaluation(s) (remote), up to 90 days, substernal lead implantable cardioverter-defibrillator system with interim analysis, review(s) and report(s) by a physician or other qualified health care professional	Yes	No	Refer to the NCD for Implantable Cardioverter Defibrillators (ICDs) (20.4)
0579T	Interrogation device evaluation(s) (remote), up to 90 days, substernal lead implantable cardioverter-defibrillator system, remote data acquisition(s), receipt of transmissions and technician review, technical support and distribution of results	Yes	No	Refer to the NCD for Implantable Cardioverter Defibrillators (ICDs) (20.4)
0580T	Removal of substernal implantable defibrillator pulse generator only	Yes	No	Refer to the NCD for Implantable Cardioverter Defibrillators (ICDs) (20.4)
0581T	Ablation, malignant breast tumor(s), percutaneous, cryotherapy, including imaging guidance when performed, unilateral	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0583T	Tympanostomy (requiring insertion of ventilating tube), using an automated tube delivery system, iontophoresis local anesthesia	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0594T	Osteotomy, humerus, with insertion of an externally controlled intramedullary lengthening device, including intraoperative imaging, initial and subsequent alignment assessments, computations of adjustment schedules, and management of the intramedullary lengthening device	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0600T	Ablation, irreversible electroporation; 1 or more tumors per organ, other than liver or prostate, including imaging guidance, when performed, percutaneous	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

Code	Description	CMS NCD Coverage Criteria	CMS LCD/LCA Coverage Criteria	Conclusion
0601T	Ablation, irreversible electroporation; 1 or more tumors, including fluoroscopic and ultrasound guidance, when performed, open	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0607T	Remote monitoring of an external continuous pulmonary fluid monitoring system, including measurement of radiofrequency-derived pulmonary fluid levels, heart rate, respiration rate, activity, posture, and cardiovascular rhythm (e.g., ECG data), transmitted to a remote 24-hour attended surveillance center; set-up and patient education on use of equipment	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0608T	Remote monitoring of an external continuous pulmonary fluid monitoring system, including measurement of radiofrequency-derived pulmonary fluid levels, heart rate, respiration rate, activity, posture, and cardiovascular rhythm (e.g., ECG data), transmitted to a remote 24-hour attended surveillance center; analysis of data received and transmission of reports to the physician or other qualified health care professional	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0614T	Removal and replacement of substernal implantable defibrillator pulse generator	Yes	No	Refer to the NCD for Implantable Cardioverter Defibrillators (ICDs) (20.4)
0615T	Automated analysis of binocular eye movements without spatial calibration, including disconjugacy, saccades, and pupillary dynamics for the assessment of concussion, with interpretation and report	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0616T	Insertion of iris prosthesis, including suture fixation and repair or removal of iris, when performed, without removal of crystalline lens or intraocular lens, without insertion of intraocular lens (Deleted 12/31/2024 – See 66683)	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0617T	Insertion of iris prosthesis, including suture fixation and repair or removal of iris, when performed; with removal of crystalline lens and insertion of intraocular lens (Deleted 12/31/2024 – See 66683)	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0618T	Insertion of iris prosthesis, including suture fixation and repair or removal of iris, when performed; with secondary intraocular lens placement or intraocular lens exchange (Deleted 12/31/2024 – See 66683)	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

Code	Description	CMS NCD Coverage Criteria	CMS LCD/LCA Coverage Criteria	Conclusion
0631T	Transcutaneous visible light hyperspectral imaging measurement of oxyhemoglobin, deoxyhemoglobin, and tissue oxygenation, with interpretation and report, per extremity (Deleted 12/13/2025)	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0640T	Noncontact near-infrared spectroscopy (e.g., for measurement of deoxyhemoglobin, oxyhemoglobin, and ratio of tissue oxygenation), other than for screening for peripheral arterial disease, image acquisition, interpretation, and report; first anatomic site	No	**Palmetto**** L39385 (A59158)	**For coverage guidelines for states/territories with no LCDs/LCAs**, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0647T	Insertion of gastrostomy tube, percutaneous, with magnetic gastropexy, under ultrasound guidance, image documentation and report	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0651T	Magnetically controlled capsule endoscopy, esophagus through stomach, including intraprocedural positioning of capsule, with interpretation and report	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0658T	Electrical impedance spectroscopy of 1 or more skin lesions for automated melanoma risk score	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0659T	Transcatheter intracoronary infusion of supersaturated oxygen in conjunction with percutaneous coronary revascularization during acute myocardial infarction, including catheter placement, imaging guidance (e.g., fluoroscopy), angiography, and radiologic supervision and interpretation	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0664T	Donor hysterectomy (including cold preservation); open, from cadaver donor	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0665T	Donor hysterectomy (including cold preservation); open, from living donor	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

Code	Description	CMS NCD Coverage Criteria	CMS LCD/LCA Coverage Criteria	Conclusion
0666T	Donor hysterectomy (including cold preservation); laparoscopic or robotic, from living donor	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0667T	Donor hysterectomy (including cold preservation); recipient uterus allograft transplantation from cadaver or living donor	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0668T	Backbench standard preparation of cadaver or living donor uterine allograft prior to transplantation, including dissection and removal of surrounding soft tissues and preparation of uterine vein(s) and uterine artery(ies), as necessary	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0669T	Backbench reconstruction of cadaver or living donor uterus allograft prior to transplantation; venous anastomosis, each	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0670T	Backbench reconstruction of cadaver or living donor uterus allograft prior to transplantation; arterial anastomosis, each	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0692T	Therapeutic ultrafiltration	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0694T	3-dimensional volumetric imaging and reconstruction of breast or axillary lymph node tissue, each excised specimen, 3-dimensional automatic specimen reorientation, interpretation and report, real-time intraoperative	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0695T	Body surface-activation mapping of pacemaker or pacing cardioverter-defibrillator lead(s) to optimize electrical synchrony, cardiac resynchronization therapy device, including connection, recording, disconnection, review, and report; at time of implant or replacement	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0696T	Body surface-activation mapping of pacemaker or pacing cardioverter-defibrillator lead(s) to optimize electrical synchrony, cardiac resynchronization therapy device, including connection, recording, disconnection, review, and	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical

Code	Description	CMS NCD Coverage Criteria	CMS LCD/LCA Coverage Criteria	Conclusion
0696T	report; at time of follow-up interrogation or programming device evaluation	No	No	Policy titled Omnibus Codes.
0735T	Preparation of tumor cavity, with placement of a radiation therapy applicator for intraoperative radiation therapy (IORT) concurrent with primary craniotomy (List separately in addition to code for primary procedure)	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0766T	Transcutaneous magnetic stimulation by focused low-frequency electromagnetic pulse, peripheral nerve, with identification and mapping of the treatment location, including noninvasive electroneurographic localization (nerve conduction localization), when performed; first nerve	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0767T	Transcutaneous magnetic stimulation by focused low-frequency electromagnetic pulse, peripheral nerve, with identification and mapping of the treatment location, including noninvasive electroneurographic localization (nerve conduction localization), when performed; each additional nerve (List separately in addition to code for primary procedure)	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0859T	Noncontact near-infrared spectroscopy (e.g., for measurement of deoxyhemoglobin, oxyhemoglobin, and ratio of tissue oxygenation), other than for screening for peripheral arterial disease, image acquisition, interpretation, and report; each additional anatomic site (List separately in addition to code for primary procedure)	No	**Palmetto**** L39385 (A59158)	**For coverage guidelines for states/territories with no LCDs/LCAs**, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0861T	Removal of pulse generator for wireless cardiac stimulator for left ventricular pacing; both components (battery and transmitter)	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0862T	Relocation of pulse generator for wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming; battery component only	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0863T	Relocation of pulse generator for wireless cardiac stimulator for left ventricular pacing, including device interrogation and programming; transmitter component only	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

Code	Description	CMS NCD Coverage Criteria	CMS LCD/LCA Coverage Criteria	Conclusion
0870T	Implantation of subcutaneous peritoneal ascites pump system, percutaneous, including pump-pocket creation, insertion of tunneled indwelling bladder and peritoneal catheters with pump connections, including all imaging and initial programming, when performed	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0871T	Replacement of a subcutaneous peritoneal ascites pump, including reconnection between pump and indwelling bladder and peritoneal catheters, including initial programming and imaging, when performed	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0872T	Replacement of indwelling bladder and peritoneal catheters, including tunneling of catheter(s) and connection with previously implanted peritoneal ascites pump, including imaging and programming, when performed	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0873T	Revision of a subcutaneously implanted peritoneal ascites pump system, any component (ascites pump, associated peritoneal catheter, associated bladder catheter), including imaging and programming, when performed	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0874T	Removal of a peritoneal ascites pump system, including implanted peritoneal ascites pump and indwelling bladder and peritoneal catheters	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
0875T	Programming of subcutaneously implanted peritoneal ascites pump system by physician or other qualified health care professional	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
1020T	Raman spectroscopy of 1 or more skin lesions, with probability score for malignant risk derived by algorithmic analysis of data from each lesion	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
17999	Unlisted procedure, skin, mucous membrane and subcutaneous tissue	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

Code	Description	CMS NCD Coverage Criteria	CMS LCD/LCA Coverage Criteria	Conclusion
19105	Ablation, cryosurgical, of fibroadenoma, including ultrasound guidance, each fibroadenoma	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
19294	Preparation of tumor cavity, with placement of a radiation therapy applicator for intraoperative radiation therapy (IORT) concurrent with partial mastectomy (List separately in addition to code for primary procedure)	No	**Palmetto**** L37779 (A56684)	**For coverage guidelines for states/territories with no LCDs/LCAs**, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
27458	Osteotomy(ies), femur, unilateral, with insertion of an externally controlled intramedullary lengthening device, including iliotibial band release when performed, imaging, alignment assessments, computations of adjustment schedules, and management of the intramedullary lengthening device	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
27713	Osteotomy(ies), tibia, including fibula when performed, unilateral, with insertion of an externally controlled intramedullary lengthening device, including imaging, alignment assessments, computations of adjustment schedules, and management of the intramedullary lengthening device	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
43206	Esophagoscopy, flexible, transoral; with optical endomicroscopy	No	**Novitas**** L35350 (A57414) **Palmetto**** L34434 (A56389)	**For coverage guidelines for states/territories with no LCDs/LCAs**, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
43252	Esophagogastroduodenoscopy, flexible, transoral; with optical endomicroscopy	No	**Novitas**** L35350 (A57414) **Palmetto**** L34434 (A56389)	**For coverage guidelines for states/territories with no LCDs/LCAs**, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
47384	Ablation, irreversible electroporation, liver, 1 or more tumors, including imaging guidance, percutaneous (Effective 01/01/2026)	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

Code	Description	CMS NCD Coverage Criteria	CMS LCD/LCA Coverage Criteria	Conclusion
53451	Periurethral transperineal adjustable balloon continence device; bilateral insertion, including cystourethroscopy and imaging guidance	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
53452	Periurethral transperineal adjustable balloon continence device; unilateral insertion, including cystourethroscopy and imaging guidance	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
53453	Periurethral transperineal adjustable balloon continence device; removal, each balloon	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
53454	Periurethral transperineal adjustable balloon continence device; percutaneous adjustment of balloon(s) fluid volume	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
63268	Laminectomy for excision or evacuation of intraspinal lesion other than neoplasm, extradural; sacral	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
64654	Initial open implantation of baroreflex activation therapy (BAT) modulation system, including lead placement onto the carotid sinus, lead tunnelling, connection to a pulse generator placed in a distant subcutaneous pocket (i.e., total system), and intraoperative interrogation and programming (Effective 01/01/2026)	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
64655	Revision or replacement of baroreflex activation therapy (BAT) modulation system, with intraoperative interrogation and programming; lead only (Effective 01/01/2026)	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
64656	Revision or replacement of baroreflex activation therapy (BAT) modulation system, with intraoperative interrogation and programming; pulse generator only (Effective 01/01/2026)	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

Code	Description	CMS NCD Coverage Criteria	CMS LCD/LCA Coverage Criteria	Conclusion
64657	Removal of baroreflex activation therapy (BAT) modulation system; total system, including lead and pulse generator (Effective 01/01/2026)	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
64658	Removal of baroreflex activation therapy (BAT) modulation system; lead only (Effective 01/01/2026)	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
64659	Removal of baroreflex activation therapy (BAT) modulation system; pulse generator only (Effective 01/01/2026)	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
64728	Decompression; median nerve at the carpal tunnel, percutaneous, with intracarpal tunnel balloon dilation, including ultrasound guidance	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
66683	Implantation of iris prosthesis, including suture fixation and repair or removal of iris, when performed (Effective 01/01/2025)	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
80145	Adalimumab	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
80230	Infliximab	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
80280	Vedolizumab	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

Code	Description	CMS NCD Coverage Criteria	CMS LCD/LCA Coverage Criteria	Conclusion
81599	Unlisted multianalyte assay with algorithmic analysis (when used to report PreTrm)	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
88375	Optical endomicroscopic image(s), interpretation and report, real-time or referred, each endoscopic session	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
90999	Unlisted dialysis procedure, inpatient or outpatient (when used to report aquapheresis (ultrafiltration))	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
92288	Screening dark adaptation measurement (e.g., rod recovery intercept time), with interpretation and report	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
93145	Interrogation device evaluation (in person), carotid sinus baroreflex activation therapy (BAT) modulation system including telemetric iterative communication with the implantable device to monitor device diagnostics and programmed therapy values, with interpretation and report (e.g., battery status, lead impedance, pulse amplitude, pulse width, therapy frequency, pathway mode, burst mode, therapy start/stop times each day); without programming (Effective 01/01/2026)	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
93146	Interrogation device evaluation (in person), carotid sinus baroreflex activation therapy (BAT) modulation system including telemetric iterative communication with the implantable device to monitor device diagnostics and programmed therapy values, with interpretation and report (e.g., battery status, lead impedance, pulse amplitude, pulse width, therapy frequency, pathway mode, burst mode, therapy start/stop times each day); with programming, including optimization of tolerated therapeutic level setting (Effective 01/01/2026)	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
93998	Unlisted noninvasive vascular diagnostic study [when used to report contact near-infrared spectroscopy studies of wounds]	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

Code	Description	CMS NCD Coverage Criteria	CMS LCD/LCA Coverage Criteria	Conclusion
94011	Measurement of spirometric forced expiratory flows in an infant or child through 2 years of age	No	**Noridian** L34149	**For coverage guidelines for states/territories with no LCDs/LCAs**, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
94012	Measurement of spirometric forced expiratory flows, before and after bronchodilator, in an infant or child through 2 years of age	No	**Noridian** L34149	**For coverage guidelines for states/territories with no LCDs/LCAs**, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
94013	Measurement of lung volumes (i.e., functional residual capacity [FRC], forced vital capacity [FVC], and expiratory reserve volume [ERV]) in an infant or child through 2 years of age	No	**Noridian** L34149	**For coverage guidelines for states/territories with no LCDs/LCAs**, refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
C1839	Iris prosthesis	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
E1399	Durable medical equipment, miscellaneous [when used to report robotic lower body exoskeleton device]	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
E1399	Durable medical equipment, miscellaneous (when used to report non-invasive bimodal neuromodulation)	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
K1007	Bilateral hip, knee, ankle, foot (HKAFO) device, powered, includes pelvic component, single or double upright(s), knee joints any type, with or without ankle joints any type, includes all components and accessories, motors, microprocessors, sensors	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
K1030	External recharging system for battery (internal) for use with implanted cardiac contractility modulation generator, replacement only	Yes	No	Refer to the NCD for Cardiac Contractility Modulation (CCM) for Heart Failure (HF) (20.39)

Code	Description	CMS NCD Coverage Criteria	CMS LCD/LCA Coverage Criteria	Conclusion
L8608	Miscellaneous external component, supply or accessory for use with the Argus II Retinal Prosthesis System	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.
L8699	Prosthetic implant, not otherwise specified [when used to report three-dimensional (3-D) printed cranial implants]	No	No	Not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled Omnibus Codes.

Centers for Medicare and Medicaid Services (CMS) Related Documents

Medicare Administrative Contractor (MAC) With Corresponding States/Territories	
MAC Name (Abbreviation)	**States/Territories**
CGS Administrators, LLC (CGS)	KY, OH
First Coast Service Options, Inc. (First Coast)	FL, PR, VI
National Government Services, Inc. (NGS)	CT, IL, ME, MA, MN, NH, NY, RI, VT, WI
Noridian Healthcare Solutions, LLC (Noridian)	AS, AK, AZ, CA, GU, HI, ID, MT, NV, ND, Northern Mariana Islands, OR, SD, UT, WA, WY
Novitas Solutions, Inc. (Novitas)	AR, CO, DC, DE, LA, MD, MS, NJ, NM, OK, PA, TX, VA**
Palmetto GBA (Palmetto)	AL, GA, NC, SC, TN, VA**, WV
Wisconsin Physicians Service Insurance Corporation (WPS)*	IA, IN, KS, MI, MO, NE
Notes	
*Wisconsin Physicians Service Insurance Corporation: Contract Number 05901 applies only to WPS Legacy Mutual of Omaha MAC A Providers. **For the state of Virginia: Part B services for the city of Alexandria and the counties of Arlington and Fairfax are excluded for the Palmetto GBA jurisdiction and included within the Novitas Solutions, Inc. jurisdiction.	

Others

L36021 MolDX: Molecular Diagnostic Tests (MDT)
A59646 Billing and Coding: MolDX: Proteomics Testing
L35160 MolDX: Molecular Diagnostic Tests (MDT)
A59641 Billing and Coding: MolDX: Proteomics Testing
L36256 MolDX: Molecular Diagnostic Tests (MDT)
A59642 Billing and Coding: MolDX: Proteomics Testing
L35025 MolDX: Molecular Diagnostic Tests (MDT)
A59636 Billing and Coding: MolDX: Proteomics Testing
L36807 MolDX: Molecular Diagnostic Tests (MDT)
A59649 Billing and Coding: MolDX: Proteomics Testing

Policy History/Revision Information

Date	Summary of Changes
06/01/2026	**Coverage Rationale** • Removed content/language addressing:

Date	Summary of Changes
	○ Bronchoscopy, rigid or flexible, including fluoroscopic guidance (CPT code 31634) ○ Surface radiation therapy (CPT code 77347) (refer to the Medicare Coverage Database for applicable coverage guidelines) ○ Transluminal peripheral atherectomy (CPT code 0237T) (refer to the Medicare Coverage Database for applicable coverage guidelines) ***Percutaneous Decompression of the Median Nerve at the Carpal Tunnel (CPT Code 64728)*** • Added language to indicate [the service is] not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled *Omnibus Codes* ***Raman Spectroscopy with Algorithmic Analysis of Data Per Skin Lesion (CPT Code 1020T)*** • Added language to indicate [the service is] not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled *Omnibus Codes* ***Repair, Revision, and/or Reconstruction Procedures on the Femur (Thigh Region) and Knee Joint (CPT Code 27458)*** • Added language to indicate [the service is] not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled *Omnibus Codes* ***Repair, Revision, and/or Reconstruction Procedures on the Leg (Tibia and Fibula) and Ankle Joint (CPT Code 27713)*** • Added language to indicate [the service is] not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled *Omnibus Codes* ***Screening Dark Adaptation Measurement (CPT Code 92288)*** • Added language to indicate [the service is] not reasonable and necessary; refer to the UnitedHealthcare Commercial Medical Policy titled *Omnibus Codes* **Supporting Information** • Archived previous policy version MMP107.08

Instructions for Use

The Medicare Advantage Policy documents are generally used to support UnitedHealthcare coverage decisions. It is expected providers retain or have access to appropriate documentation when requested to support coverage. This document may be used as a guide to help determine applicable:

- Medical necessity coverage guidelines; including documentation requirements, and/or
- Medicare coding or billing requirements.

Medicare Advantage Policies are applicable to UnitedHealthcare Medicare Advantage Plans offered by UnitedHealthcare and its affiliates. This Policy is provided for informational purposes and does not constitute medical advice. It is intended to serve only as a general reference and is not intended to address every aspect of a clinical situation. Physicians and patients should not rely on this information in making health care decisions. Physicians and patients must exercise their independent clinical discretion and judgment in determining care. Treating physicians and healthcare providers are solely responsible for determining what care to provide to their patients. Members should always consult their physician before making any decisions about medical care.

Benefit coverage for health services is determined by the member specific benefit plan document and applicable laws that may require coverage for a specific service. The member specific benefit plan document identifies which services are covered, which are excluded, and which are subject to limitations. In the event of a conflict, the member specific benefit plan document supersedes this policy. For more information on a specific member's benefit coverage, call the customer service number on the back of the member ID card or refer to the Administrative Guide.

Medicare Advantage Policies are developed as needed, are regularly reviewed, and updated, and are subject to change. They represent a portion of the resources used to support UnitedHealthcare coverage decision making. UnitedHealthcare may modify these Policies at any time by publishing a new version on this website. Medicare source materials used to develop these policies may include, but are not limited to, CMS statutes, regulations, National Coverage Determinations (NCDs), Local Coverage Determinations (LCDs), and manuals. This document is not a replacement for the Medicare source materials that outline Medicare coverage requirements. The information presented in this Policy is believed to be accurate and current as of the date of publication. Where there is a conflict between this document and Medicare source

materials, the Medicare source materials apply. Medicare Advantage Policies are the property of UnitedHealthcare. Unauthorized copying, use, and distribution of this information are strictly prohibited.

UnitedHealthcare follows Medicare coverage guidelines found in statutes, regulations, NCDs, and LCDs to determine coverage. The clinical coverage criteria governing certain items or services referenced in this Medical Policy have not been fully established in applicable Medicare guidelines because there is an absence of any applicable Medicare statutes, regulations, NCDs, or LCDs setting forth coverage criteria and/or the applicable NCDs or LCDs include flexibility that explicitly allows for coverage in circumstances beyond the specific indications that are listed in an NCD or LCD. As a result, in these circumstances, UnitedHealthcare applies internal coverage criteria as referenced in this Medical Policy. The internal coverage criteria in this Medical Policy was developed through an evaluation of the current relevant clinical evidence in acceptable clinical literature and/or widely used treatment guidelines. UnitedHealthcare evaluated the evidence to determine whether it was of sufficient quality to support a finding that the items or services discussed in the policy might, under certain circumstances, be reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member.

Providers are responsible for submission of accurate claims. Medicare Advantage Policies are intended to ensure that coverage decisions are made accurately. UnitedHealthcare Medicare Advantage Policies use Current Procedural Terminology (CPT®), Centers for Medicare and Medicaid Services (CMS), or other coding guidelines. References to CPT® or other sources are for definitional purposes only and do not imply any right to reimbursement or guarantee claims payment.

For members in UnitedHealthcare Medicare Advantage plans where a delegate manages utilization management and prior authorization requirements, the delegate’s requirements need to be followed.